TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Spine Joint

Respondent Name
Liberty Mutual Insurance Co

MFDR Tracking Number
M4-17-0485-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
October 24, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Therefore, it is our position that Liberty Mutual' s denial is erroneous, because it is clear from the guidelines that the Hospital's bill is properly coded."

Amount in Dispute: $22,592.34

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Previously paid billed CPT 17999 at 200% rate per Texas Fee Schedule. Addendum B prices to $117.83 at 100%. $117.83 x 200% = $235.66. This was accurately adjudicated at the time of initial processing. Services billed without CPT or HCPCS codes were denied CPT OR HCPC IS REQUIRED TO DETERMINE IF SERVICE ARE PAYABLE (X936). HCPCS J codes, CPT 85027 and CPT 36415 are packaged items per OPPS and were denied Procedure code not separately payable under Medicare and or Fee Schedule guidelines. (U634)."

Response Submitted by: Liberty Mutual Insurance Co

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 11, 2016	Outpatient Hospital Services	$22,592.34	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for services provided in

outpatient hospital services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - X936 – CPT or HCPC is required to determine if services are payable
   - U634 – Procedure code not separately payable under Medicare and or fee schedule guidelines
   - Z652 – Recommendation of payment has been based on a procedure code which best describes services rendered
   - Z710 – the charge for this procedure exceeds the fee schedule allowance
   - P300 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
   - 193 – CPT or HCPC is required to determine if services are payable
   - W3 – CPT or HCPC is required to determine if services

The services in dispute are for outpatient hospital services and are therefore subject to the requirements of 28 Texas Administrative Code 134.403 (d) which states in pertinent part, "For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided..." The applicable Medicare payment policy may be found at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS.

In order to calculate the correct Division fee guideline, stakeholders should be familiar with the main components in the calculation of the Medicare payment for OPPS services, which are:

1. **How Payment Rates Are Set**, found at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysysfctsht.pdf,

   To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) is further adjusted by the hospital wage index for the area where payment is being made. The remaining 40 percent is not adjusted.

2. **Payment status indicator** - The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule. The relevant status indicator may be found at the following: www.cms.gov, Hospital Outpatient Prospective Payment – Final Rule, OPPS Addenda, Addendum D1.

3. **APC payment groups** - Each HCPCS code for which separate payment is made under the OPPS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. The relevant payment amount for each APC may be found at www.cms.gov, Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Annual-Policy-Files, Addendum B. These files are updated quarterly.

1. Is the requestor's position supported?
2. What is the applicable rule pertaining to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor states, "The documents from the American Hospital Association attached shows that for revenue 0250 HCPCS codes are not required. While they are recommended, they are not required. For revenue Code 0258, the guidelines specifically state, "OPPS does not require HCPCS codes for this revenue code." This is also stated for revenue codes 0272, 0370, and 0710." 28 Texas Administrative Code 134.403 (d) states in pertinent part,

   For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided...

The Medicare Claims Processing Manual, Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS), 20 - Reporting Hospital Outpatient Services Using Healthcare Common Procedure Coding System (HCPCS) 20.1, General, found at www.cms.hhs.gov, states,

> *The HCPCS codes are required for all outpatient hospital services unless specifically excepted in manual instructions. This means that codes are required on surgery, radiology, other diagnostic procedures, clinical diagnostic laboratory, durable medical equipment, orthotic-prosthetic devices, take-home surgical dressings, therapies, preventative services, immunosuppressive drugs, other covered drugs, and most other services.*
>
> *When medical and surgical supplies (other than prosthetic and orthotic devices as described in the Medicare Claims Processing Manual, Chapter 20, §10.1) described by HCPCS codes with status indicators other than "H" or "N" are provided incident to a physician's service by a hospital outpatient department, the HCPCS codes for these items should not be reported because these items represent supplies. Claims containing charges for medical and surgical supplies used in providing hospital outpatient services are submitted to the Medicare contractor providing OPPS payment for the services in which they are used.* ***The hospital should include charges associated with these medical and surgical supplies on claims so their costs are incorporated in ratesetting, and payment for the supplies is packaged into payment for the associated procedures under the OPPS in accordance with 42 CFR 419.2(b)(4).***

The Division finds the requestor's position is supported. However, the medical and surgical supplies indicated by only revenue codes are packaged under OPPS as stated above. Based on the Medicare payment policy a review of the submitted HCPCS codes is as follows.

2. The services in dispute are related to outpatient hospital services rendered on February 11, 2016. The requestor is seeking additional reimbursement for $22,592.34. The rule that sets out the fee guideline is 28 Texas Administrative Code §134.403 (f) which states in pertinent part,

> The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
>
> (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
>
> (A) 200 percent; unless
>
> (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

Review of the submitted medical claim finds separate reimbursement for implantables was not requested therefore, the services in dispute are reimbursed based on the following:

Submitted code	Status Indicator	APC	Payment Rate	Unadjusted labor amount = APC payment x 60%	Geographically adjusted labor amount = unadjusted labor amount x annual wage index 0.8223	Non labor portion = APC payment rate x 40%	Medicare facility specific reimbursement (geographically adjusted labor) amount + non labor portion)	Maximum Allowable Reimbursement
17999	Q1	5051	$117.83	$117.83 x 60% = $70.70	$70.70 x 0.8223 = $58.14	$117.83 x 40% = $47.13	$58.14 + $47.13 = $105.27	$105.27 x 200% = $210.54
							Total	$210.54

The remaining billed codes have the following status indicators:

- Procedure code J0690 has status indicator N denoting packaged codes with no separate payment.
- Procedure code J3010 has status indicator N denoting packaged codes with no separate payment.
- Procedure code J2250 has status indicator N denoting packaged codes with no separate payment.
- Procedure code J1100 has status indicator N denoting packaged codes with no separate payment.
- Procedure code J7120 has status indicator N denoting packaged codes with no separate payment.
- Procedure code 36415 - has status indicator Q4 denoting packaged APC payment if billed on the same claim as a HCPCS code assigned published status indicator "J1," "J2," "S," "T," "V," "Q1," "Q2," or "Q3." The carrier denied as U634 – "Procedure code not separately payable under Medicare and or fee schedule guidelines." Review of the submitted medical claim finds Code 17999 has a status indicator of Q1. Based on the above, the carrier's denial is supported.
- Procedure code 85027 - has status indicator Q4 denoting packaged APC payment if billed on the same claim as a HCPCS code assigned published status indicator "J1," "J2," "S," "T," "V," "Q1," "Q2," or "Q3." The carrier denied as U634 – "Procedure code not separately payable under Medicare and or fee schedule guidelines." Review of the submitted medical claim finds Code 17999 has a status indicator of Q1. Based on the above, the carrier's denial is supported.
- Procedure code J2405 has status indicator N denoting packaged codes with no separate payment.

3. The total allowable reimbursement for the services in dispute is $210.54. This amount less the amount previously paid by the insurance carrier of $235.66 leaves an amount due to the requestor of $0.00. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		November 17, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.